HEALTHCARE REGULATORY ROUND-UP - Episode #59

No Surprises Act Update

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Introductions

Martie Ross, JD
mross@pyapc.com

Kathy Reep, MBA
kreep@pyapc.com

pyapc.com
800.270.9629

No Surprises Act – The Basics

Surprise Billing

- Prohibits out-of-network (OON) facilities and providers from charging patients more than in-network cost-sharing amount for emergency services
- Applies same rule to OON provider furnishing non-emergency services at in-network facility and OON air ambulance services (not ground ambulance – yet)
- Defines process for calculating patient's in-network cost-sharing among in cases where no state process applies
- Establishes federal independent dispute resolution (IDR) process to determine OON payment rate in cases where no state process applies
- Imposes specific notice requirements

Good Faith Estimates

- Requires facilities and procedures to furnish certain notices and good faith estimates (GFEs) to self-pay patients in specified circumstances.

State vs. Federal Process

- Prior to NSA, 33 states had some version of surprise billing protections for state-regulated plans
- If applicable, follow state law process to determine patient's in-network cost-sharing and/or determine OON rate
  - Does state law apply to plan, to facility/provider, to service?
- Federal process applies if matter involves self-funded plan
  - Except in **Georgia, Maine, Nevada, New Jersey, Virginia, and Washington**, where state law permits self-funded plan to opt into state process
- Generally, state law process applies if matter involves fully-insured plans in the following states
  - **California, Colorado, Connecticut, Delaware, Florida, Georgia, Illinois, Maine, Maryland, Michigan, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Texas, Virginia, Washington**

https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf

PYA Resources

https://www.pyapc.com/healthcare-transparency/

No Surprises Act Implementation Guide

- **Part 1: Notice Requirements**
- **Part 2: Good Faith Estimate Requirements**
- **Part 3: Hospitals, Their Medical Staffs, and NSA Disclosure and Notice Requirements**
- **Part 4: The Qualifying Payment Amount — Getting Your Ducks in a Row**

On-Demand Webinar: Day 12 and Counting – The No Surprises Act: Your Questions (Hopefully) Answered & What to Expect Going Forward

On-Demand Webinar: Preparing for No Surprises Act Compliance

On-Demand Webinar: "Complying With the No Surprises Act — A Guide for Physician Practices"

On-Demand Webinar: "Ready, Set, Go — No Surprises Act Takes Effect January 1"

On-Demand Webinar: "No More Surprises – A Discussion of the Surprise Billing Interim Final Rule"

On-Demand Webinar: No Surprises Act: The New Independent Dispute Resolution Process

The Long and Winding Road

Date	Event
12/27/2020	No Surprises Act signed into law (CAA, 2021)
7/13/2021	Departments publish Interim Final Rule I (Surprise Billing + QPA)
9/16/2021	Departments publish Proposed Rule (NSA enforcement); has not been finalized
10/17/2021	Departments publish Interim Final Rule II (IDR Process + Good Faith Estimates)
1/1/2022	NSA Effective Date
2/23/22	Texas Medical Ass'n (TMA) I Decision (vacating QPA rebuttable presumption in IDR process)
4/15/22	Federal IDR process opens
8/26/2022	Departments publish Final Rule (replacing QPA rebuttable presumption in response to TMA I decision)
12/2/2022	Departments announce indefinite delay to GFE requirements relating to co-providers
12/23/2022	Departments announce increase in IDR administrative fee ($50 to $350 for 2023)
2/26/2023	TMA II Decision (vacating IDR "fix" in August 2022 Final Rule – on appeal)
8/4/2023	TMA IV Decision (vacating increase in IDR administrative fee + regulatory standard for batching claims)
8/24/2023	TMA III Decision (vacating calculation of QPA in July 2021 Interim Final Rule – Departments intent to appeal)
9/26/2023	Departments publish Proposed Rule (IDR administrative fee + CIDRE fee ranges)
??/??/???	Proposed Rule (IDR Operations)

Post-TMA III QPA Calculations

- Vacated portion of July 2021 Interim Final Rule on QPA calculation; the agencies "may not ignore the plain requirements of the Act merely because insurers may be inconvenienced."
  - Inclusion of "ghost" rates (rates with providers who do not furnish specific service at issue)
  - Inclusion of rates for physicians not in same/similar specialty
  - Exclusion of contingent payments (e.g., risk sharing, incentive-based bonuses)
  - Inclusion of rates from other plans self-insured administered by same TPA
- DOJ intends to appeal decision; agencies do not intend to issue guidance beyond 10/6/2023 FAQs
  - "[P]lans … are expected to calculate QPAs using a good faith, reasonable interpretation of the applicable statutes and regulations that remain in effect after the TMA III decision"
  - Departments will exercise enforcement discretion to permit plans to rely on July 2021 Interim Final Rule to calculate QPAs for services furnished before 5/1/2024 (may extend date but not beyond 11/1/2024)

Post-TMA III Initial Payment/Notice of Denial

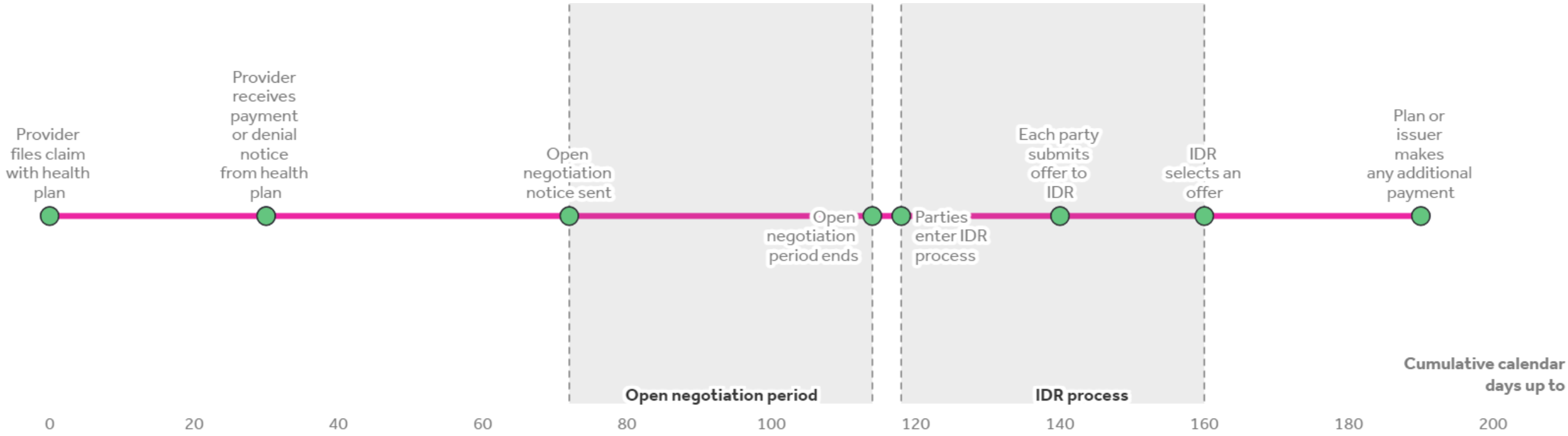
- Deadline for payer to provide initial payment/notice of denial
  - Statute: "not later than 30 calendar days after the bill for such services is transmitted to the provider"
  - July 2021 Interim Final Rule: 30-day deadline "begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services"
- TMA III decision rejected application of "clean claim" standard
- 10/6/2023 FAQs
  - "[B]efore denying a claim…because the provider did not submit sufficient information, plans…should communicate with providers to obtain the information [needed]to provide a full and fair review within the 30-calendar-day timeframe…"
  - "If a plan…cannot determine coverage in that timeframe, the plan…should issue a notice of *benefit* denial" without suggesting service was determined to be non-covered service

Federal IDR Process

Step in the Process	Must Be Completed By
Following failed open negotiation, either party may initiate IDR process by sending Notice of IDR Initiation to the Departments through federal IDR portal and to other party (electronically or by paper if requested); use standard notice and list preferred certified IDR entity (CIDRE)*	**4 business days**, starting business day after the open negotiation period ends
Non-initiating party agrees or objects to preferred CIDRE (assume agreement if no response)	**3 business days** after IDR initiation date (i.e., date Departments received notice)
Initiating party notifies Departments of (a) selection of CIDRE, or (b) failure to agree to CIDRE; non-initiating party submits reasons claim not eligible for federal IDR process (if appropriate)	**4 business days** after IDR initiation date
Departments select CIDRE (if applicable)	**6 business days** after IDR initiation date
Selected CIDRE submits to Departments attestation that it does not have a conflict of interest and determines matter is eligible for federal IDR process	**3 business days** after date of CIDRE selection
Parties submit payment offers and required data elements to CIDRE with administrative fee and CIDRE fee; failure to pay fees results in CIDRE accepting other party's payment officer	**10 business days** after date of CIDRE selection
IDR entity issues written opinion accepting one party's offer	**30 business days** after date of CIDRE selection
Payment made to provider (if successful); CIDRE fee refunded to prevailing party	**30 business days** after payment determination
Cooling off period - initiating party cannot submit subsequent Notice of IDR Initiation involving same party with respect to claim for same/similar item or service that was subject of Notice of IDR Initiation.	**90 calendar days** after payment determination

*Departments have published standard forms/data elements (including Notice of IDR Initiation, Notice of CIDRE Selection, Notice of Offer, Notice of Agreement on Out-of-Network Rate) to be used by Federal IDR participants, as well as a form to request extension of time periods due to extenuating circumstances. These documents are available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act)

Federal IDR Timeline



https://www.healthsystemtracker.org/brief/independent-dispute-resolution-explainer/

Post-TMA IV Dispute Initiation

Date	Action
8/3/2023	Departments temporarily suspend federal IDR functions
9/21/2023	Departments direct CIDREs to resume processing non-batched disputes submitted on/before 8/3/2023
10/6/2023	Departments reopen Federal IDR portal for initiation of new non-batched disputes
10/20/2023	Extended deadline to select certified IDR entity for parties engaged in selection process on 8/3/2023
11/3/2023	Extended deadline to initiate Federal IDR process (if four days following end of open negotiation period occurred between 8/3/2023 and 11/3/2023)
TBD	Re-opening of Federal IDR process for batched disputes and air ambulance disputes

Statute: Batched items/services must be "related to the treatment of a similar condition"

Regulation: Batched items/services must be "same or similar items or services," i.e., each must "be billed under the same service code, or a comparable code under a different procedural code system"

https://www.cms.gov/files/document/federal-idr-partial-reopening-faqs-oct-23.pdf

Proposed Rule – IDR Administrative Fee and CIDRE Fee Ranges

- Establish administrative fee through notice and comment rulemaking
  - Project annual cost of $70 million to maintain federal IDR process
    - Maintaining portal, approving CIDREs, conducting program integrity activities (QPA and IDR decision audits), providing technical assistance, collecting fees, assist with eligibility determinations
  - Project 225,000 closed disputes annually (450,000 administrative fees paid)
  - Proposed fee $150 per party per dispute to remain in effect until subsequent rulemaking
- Establish CIDRE fee ranges through notice and comment rulemaking
  - Propose single determination range of $200 to $840 (20% increase to upper limit)
  - Propose batched determination range of $268 to $1,173 (25% increase to upper limit) + may charge add'l fixed tiered fee of $75 to $250 for each add'l 25 line items
  - CIDRE must annually provide fixed fee for single and batched determinations
- Comments due **October 26**

https://www.govinfo.gov/content/pkg/FR-2023-09-26/pdf/2023-20799.pdf

Post-TMA II CIDRE Decision-Making

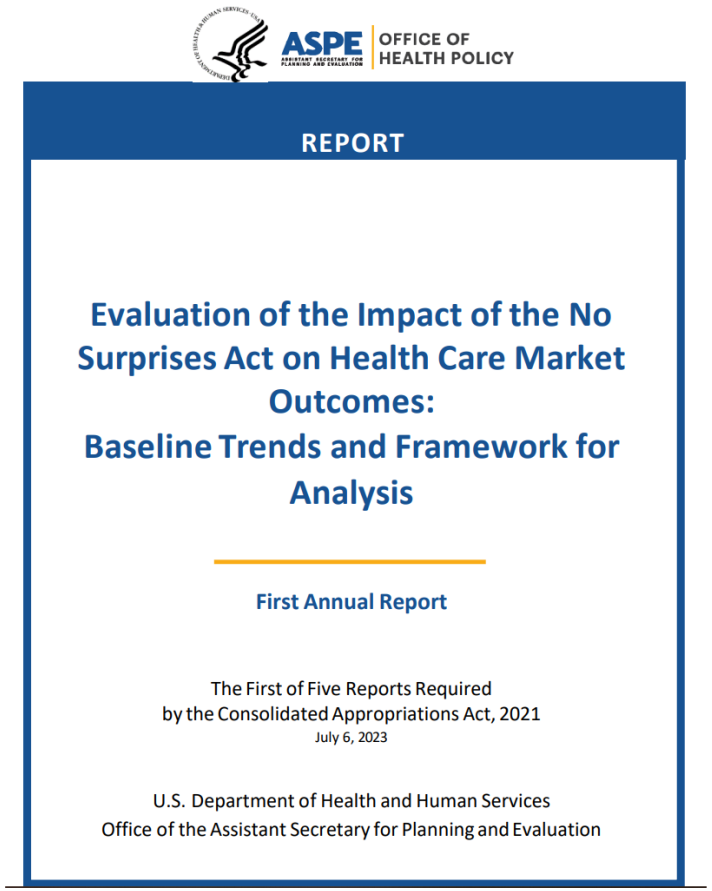
- August 2022 Final Rule (following TMA I decision) directs CIDREs to -
  - Consider QPA first
  - Forego consideration of additional statutory circumstances accounted for in QPA
  - Explain in writing why any additional circumstances were considered
- Court determined new regulation still gave too much deference to QPA
- Pending appeal, CIDREs must apply plain language of statute and determine OON without giving any statutory circumstance special weight

IDR Process – 4/15/2022 to 3/31/2023

Action	Cases	Commentary
Initiated Disputes	334,828	14x greater than estimated
Eligibility Challenges	122,781	37% of initiated disputes
Closed Disputes	106,615	32% of initiated disputes
Ineligible Disputes	39,890	37% of closed disputes
Payment Determinations	42,158	49% of closed disputes
Initiating Party Prevailed	*29,932*	71% of payment determinations
Non-Initiating Party Prevailed	*12,226*	29% of payment determinations
Closed for Other Reasons	24,567	23% of closed disputes

https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf

NSA Impact


ASPE OFFICE OF HEALTH POLICY

REPORT

Evaluation of the Impact of the No Surprises Act on Health Care Market Outcomes:
Baseline Trends and Framework for Analysis

First Annual Report

The First of Five Reports Required
by the Consolidated Appropriations Act, 2021
July 6, 2023

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation

- Mandated annual reports to Congress
- Reviews studies on impact of state surprise billing laws
  - Decrease in in-network and OON prices
- Defines framework for evaluating impact on prices, spending, quality, access to care, and market consolidation

https://aspe.hhs.gov/sites/default/files/documents/48b874b63796dc6a68a783cf079ba42a/aspe-no-surprises-act-rtc.pdf

8/19/22 FAQs - Plans Utilizing Reference-Based Pricing

- Plan pays provider referenced-based amount with patient responsible for difference between that amount and provider's billed charges
- NSA applies to emergency services only (no in-network facility at which OON provider furnishes non-emergency services)
- Plan calculates QPA using eligible database (no contracted rates)
  - If plan does not impose cost-sharing requirement, provider cannot bill for difference between referenced-based amount and provider's billed charges
- Plan may be required by CIDRE to make payment different from reference-based pricing for emergency services

https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-55.pdf

8/19/22 FAQs: Plans With No OON Coverage

- Plan that provides any benefit for ED services must cover emergency services furnished by OON provider
- Plan that provides any benefit for non-emergency services furnished at in-network facility must cover OON provider's services at that facility
- In effect, NSA requires OON coverage in specified circumstances

Our Next Healthcare Regulatory Round-Up Webinar

CY 2024 Final Rules

Wednesday, November 8